*Please return the completed form to:*

**The University of the State of New York**
**THE STATE EDUCATION DEPARTMENT**
**Office of Adult Career and Continuing Education Services-Vocational Rehabilitation (ACCES-VR)**

# Application for VR Services

VR-04 (7/14)

*Please print or type all entries*

| **NAME** *Last* *First* *Middle Initial* | GENDER ☐ Male ☐ Female |
|---|---|
| If you have been known by **another name**, enter here: *Last* *First* *Middle Initial* | |
| **HOME ADDRESS** *Street* *Apartment Number* | |
| *City* *State* *Zip + 4 Code* *County* | SOCIAL SECURITY NUMBER ☐☐☐-☐☐-☐☐☐☐ |
| If your **MAILING ADDRESS** is different than your home address, please complete the mailing address information below. | |
| **MAILING ADDRESS** *Street* *Apartment Number* | |
| *City* *State* *Zip + 4 Code* *County* | |

| PHONE NUMBER(S) *where we can reach you or leave a message:* | *Best time to call* | DATE OF BIRTH |
|---|---|---|
| *Area code* 1. ( ) - *Home* ☐ *Cell* ☐ *Other* ☐   *Area code* 2. ( ) *Home* ☐ *Cell* ☐ *Other* ☐ <br> *Email:*______________________ | 1. <br> 2. | Month Day Year <br> ☐☐-☐☐-☐☐ |

| Race/Ethnicity-Choose ALL that apply. If left blank ACCES will complete. If Hispanic or Latino is checked, please check additional box. | ☐ American Indian or Alaska Native <br> ☐ Asian (includes Indian Subcontinent) <br> ☐ Black or African American | ☐ Hispanic or Latino <br> ☐ Native Hawaiian or Other Pacific Islander <br> ☐ White |
|---|---|---|

| What is your disability? | Who referred you to us? | MARITAL STATUS: (*Circle Response)* (1) Married; (2) Widowed; (3) Divorced (4) Separated (5) Never Married |
|---|---|---|

**I hereby apply for rehabilitation services:** *Signature of applicant, parent, or legal guardian.*

*Date*____________

***X*** *(Sign here.)*

• • • ***Please answer the questions below and on the back of this form.*** • • •

**You do not have to answer these questions now, but your answers will help ACCES-VR process your application.**

Have you ever received services from ACCES-VR or its former name, the Office of Vocational and Educational Services for Individuals with Disabilities (VESID)?.................................................................................. ☐ Yes ☐ No

Are you now receiving services from *one* or *more* agencies?.......................................... ☐ Yes ☐ No

***If you answered yes, indicate agency name(s), address(es) and contact person(s):***

(1)

(2)

Describe how your disability limits your ability to work.

What services are you seeking from ACCES-VR?

Are you disabled because of a work-related injury? ☐ Yes ☐ No

Do you use any assistive devices or aids? ☐ Yes ☐ No

Do you have a NYS driver's license? ☐ Yes ☐ No

Do you have a driver's license from a state other than New York? ☐ Yes ☐ No

Do you have access to a motor vehicle? ☐ Yes ☐ No

Do you use public transportation? ☐ Yes ☐ No

Are you able to leave your home? ☐ Yes ☐ No

Are you a veteran? ☐ Yes ☐ No

Are you a citizen of the United States? ☐ Yes ☐ No

If no, are you legally permitted to work in this country? ☐ Yes ☐ No

Check the benefits you now receive?

☐ SSI ☐ SSDI ☐ Workers Compensation

☐ Other, specify_____________

Do you regularly see a doctor or clinic about your disability? ☐ Yes ☐ No, If yes, indicate date of last visit: ___________

Please provide the name and address of doctor(s) and clinic(s):

(1) (2)

Circle the highest grade you have successfully completed, and check the applicable box(es)

1 2 3 4 5 6 8 9 10 11 12 GED or High School Equivalency Diploma ☐ Yes ☐ No 13 14 15 16 College 17 Graduate School 20 Doctorate

Special Education ☐ Yes ☐ No Do you now attend high school? ☐ Yes ☐ No Indicate college degree(s) earned: ___________________

Name and address of school you last attended: *Name of School* *Address*

***List below other people in your household***

| Full Name | Age | Their Relationship to You |
|---|---|---|
| | | |
| | | |
| | | |

***List below the people ACCES-VR can contact if we are unable to reach you using the information on page 1.***

| Name | Address | Phone |
|---|---|---|
| | | |
| | | |

***List below your work history (include attachments for additional jobs, if necessary)***

| Employer Name and Address | Dates Employed From - To | Weekly Earnings | Job Title and Duties, and Reason for Leaving |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Persons applying for or receiving rehabilitation services have the right to have any actions or decisions of this Office reviewed. A description of the review process and form can be obtained from any ACCES-VR District Office.**

***All information will be kept confidential and is subject to verification.***

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The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of Adult Career and Continuing Education Services (ACCES-VR)

VR-21 (3/15)

# *Information Release Authorization*

**Name**: ____________________________________________
*Print full name*

The Office of Adult Career and Continuing Education Services (ACCES-VR) has my permission to release or obtain information from agencies [including the Client Assistance program (CAP)], individuals, or employers as are concerned with my vocational rehabilitation. This information may include reports about my physical or mental condition, official school records, facts necessary to determine my financial need, or other information that ACCES-VR needs to determine my eligibility and to provide vocational rehabilitation services.

I understand that:

- All such information will be treated as confidential and privileged;
- The information will be used only for the purpose of obtaining services offered through ACCES-VR;
- I can withdraw my permission to release or obtain information by writing to ACCES-VR (this will not affect actions already taken with my permission); and
- ACCES-VR may need to use the information to administer the vocational rehabilitation program

______________________________ ______________________
***Signature*** ***Date***

______________________________ ______________________
***Parent/Guardian Signature (If Under 18 Years of Age)*** ***Date***

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## ACCES-VR High School Applicant Supplemental Data

### All Information Below is Optional but Helpful for Application

### *Education Information to be completed by person making referral*

Referral will be facilitated by including **one or more** of the following: ☐ Current IEP and most recent psychological report ☐ Current 504 Plan and supporting documents ☐ Current Physician Report with diagnosis ☐ Other Relevant Information

Student Name: ______________________________ DOB ______________

CSE Classification, 504 or Medical Diagnosis: ______________________________

Grade Most Recently Completed: ____________ Expected Year of School Completion: ______________

Type of Degree/Certificate Anticipated: ☐ Regents ☐ Local ☐ CDOS ☐ Skills & Achievement

School District Student Resides In: ______________________________

School Student Attends: ____________________ AM ____________ PM ____________

Name of person making referral: ______________________________ Title: ______________

Email Contact: ______________________________ Phone Number: ______________

### *Can Choose to Complete Following with ACCES-VR Counselor at First Meeting*

### *Health, Residence & Work Questionnaire: To Be Completed By Student And Parent/Guardian*

Do you have or have you ever had any of the following conditions?

| | | | |
|---|---|---|---|
| ☐ ADHD | ☐ Depression | ☐ Intellectual Disability | ☐ Seizure Disorder |
| ☐ Allergies/Asthma | ☐ Diabetes | ☐ Kidney Disease | ☐ Skin Disease/Rash |
| ☐ Anxiety | ☐ Drug/Alcohol Abuse | ☐ Learning Disability | ☐ Speech/Language Disorder |
| ☐ Arthritis | ☐ Head Injury | ☐ Mental Illness | ☐ Stroke |
| ☐ Autism Spectrum | ☐ Hearing Loss | ☐ Muscular Dystrophy | ☐ Ulcers/Colitis/Crohn's Disease |
| ☐ Cancer | ☐ Heart Disease | ☐ Orthopedic Limitations | ☐ Vision (not corrected by glasses) |
| ☐ Cerebral Palsy | ☐ HIV Related Diseases | ☐ Respiratory Disorder | ☐ Other: ______________ |

List of Medications:

______________________________

______________________________

***Medical Insurance at Application:***

☐ Medicaid ☐ Medicare ☐ Other Private ☐ Private Through Employment ☐ Workers Compensation ☐ None

***Living Arrangements at Application:***

☐ Private Residence ☐ Foster Care ☐ Homeless ☐ Community Residence ☐ Halfway House
☐ Substance Abuse Treatment Facility ☐ Mental Health Facility ☐ Correctional Facility ☐ Other

***Work Status at Application:***

☐ Employed with a job coach ☐ Employed on my own ☐ Not presently employed